

## **Excerpts from Vermont Medicaid Policy**

### **7103 Medical Necessity**

“Medically necessary” means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary’s diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

1. help restore or maintain the beneficiary’s health; or
2. prevent deterioration or palliate the beneficiary’s condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

### **7104 Procedure for Requesting Coverage of a Service or Item**

Any beneficiary may request that the department cover a service or item that is not already included on a list of covered services and items. The request should be sent to the Director of the Office of Vermont Health Access (OVHA). The director will review the request and supporting documentation and make a good faith effort to obtain any additional information quickly to allow the commissioner to make a decision within thirty days. In no case will a request for a service or item be approved for coverage unless it is medically necessary.

Each decision shall result in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list of pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.

If the commissioner’s decision is to add the service or item to a pre-approved list of covered services, a PP&D memorandum will be issued delineating the addition. All such PP&D memoranda will be incorporated into the rule as soon as practical. An adverse decision from the commissioner may be appealed through the fair hearing process. An adverse decision may not be renewed by the same beneficiary until twelve months have elapsed since the previous final decision or until new documentation of the individual’s condition, a change in the individual’s condition, new medical evidence, or a change in technology has been demonstrated.

The Office of Vermont Health Access shall, semiannually, issue a PP&D memorandum updating the listing of all affirmative coverage decisions made under this procedure that do not result in the service or item that is authorized being added to a list of pre-approved services or items. This list shall include the commissioner’s coverage decisions, plus negotiated settlements and Human Services Board and Vermont Supreme Court decisions. Because this list shall be available for public inspection, it shall be composed in a manner that protects beneficiaries’ right to confidentiality. The department will ensure that all Medicaid beneficiaries who are similarly situated to the individual who has obtained coverage will be treated similarly with respect to coverage of the same service or item.

If, under this section, an individual requests that a service or item be covered, the following criteria will be considered, in combination, in determining whether to cover the service or item for the individual and/or to add it to a list of pre-approved services or items, with the following exception. If the service or item is subject to FDA approval and has not been approved (criterion #I below), the request for coverage of the service or item will be denied.

- A. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not approved?
- B. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?
- C. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered?
- D. Is the service or item consistent with the objectives of Title XIX?
- E. Is there a rational basis for excluding coverage of the service or item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage for a service or item solely based on its cost.
- F. Is the service or item experimental or investigational?
- G. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?
- H. Are less expensive, medically appropriate alternatives not covered or not generally available?
- I. Is FDA approval required, and if so, has the service or item been approved?
- J. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

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***The policy sections above are for information or guidance only. This page should not be returned to OVHA, and should not to be used instead of, or in addition to the Medical Need Form (211 RCMN).***